COUNTY OF LOS ANGELES

ANNUAL REPORT

OF

THE CORONER

THEO. J. CURPHEY, M.D., *Coroner*

Fiscal Year July 1, 1958—June 30, 1959

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THEO. J. CURPHEY, M.D.
CORONER

COUNTY OF LOS ANGELES

OFFICE OF CORONER
HALL OF JUSTICE
LOS ANGELES 12, CALIFORNIA

FREDERICK D. NEWBARR, M.D
CHIEF MEDICAL DIVISION

Honorable Board of Supervisors
County of Los Angeles
Los Angeles, California

Gentlemen:

Herewith is presented the annual report of the Coroner of Los Angeles County for the fiscal year ending June 30, 1959.

The report contains a statement of the functions and the organization of the office, and documents the progress currently made in the reorganization of the various divisions, aimed at providing a more scientific and efficient service to the community, comparable to the high level of efficiency and public service supplied by other departments of County Government and commensurate with the increasing importance of forensic medicine in the life of the most rapidly growing and progressive community in the nation. The report also contains a summary of the operations and selected statistics bearing on the cases investigated.

With the submission of this report goes my sincere gratitude to the members of the Board of Supervisors for their support of the program necessary to modernize the office, and also to the Chief Administrative Officer and his various departmental heads and staff personnel, who have fully cooperated to the extent of their time and their experience in aiding in the necessary changes and improvements of the past fiscal year.

Respectfully submitted,

Theo. J. Curphey

THEO. J. CURPHEY, M. D.
CORONER

FOREWORD

A continuous effort was made during 1958-59 to further improve the flow of case files under study by the various divisions. The exact whereabouts and status of any particular case is necessary so that requests for information from the public can be processed expeditiously. During the periods of heavy workload and employee's vacations, back logs developed which temporarily reduced the efficiency of this system.

Considerable difficulty was experienced with the dictation and transcription of the autopsy protocols. Frequent breakdown of equipment caused our medical stenographers difficulty in transcribing the dictation, and redictation of the protocols by the Deputy Medical Examiners was necessary in many cases.

During the same period of time mild success was attained in the matter of recruitment of qualified medical personnel. Experience in this field has shown that a better quality of professional service is given if the individual is soundly trained in basic pathology before entering into the medico-legal field. The major recruiting difficulty, based chiefly on prevailing economic conditions, lies in attracting these men to full-time positions. Our alternative has been to establish part-time positions, which in the case of younger men in the process of their special training, offers a current solution to the problem of obtaining competent professional medical service. During the fiscal year 1958-59, it was possible to attract some 15 pathologists in training who served on a part-time basis in the Department of Coroner.

Again this year the department was asked to re-evaluate the departmental space requirements up to and including the year 1970. It is hoped that in the near future conditions will permit the granting of the department adequate space in which to perform the various required functions.

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I SUMMARY OF OPERATIONS

During 1958-59 the Coroner's Department investigated 9,950 cases, nine less than were processed during 1957-58. The mild winter experienced during 1958-59 contributed to the reduced workload. Of the 9,950 cases, 4,270 were handled in the Coroner's mortuary in the Hall of Justice, while 5,680 cases were handled in private mortuaries beyond the metropolitan area serviced by the Coroner's mortuary. Of the total number of cases handled, autopsies were performed in 4,661 cases (46.9%). The Coroner's laboratories prepared 19,275 microscopic slides, and conducted toxicological studies in 3,464 cases. Inquests were held in 420 cases.

Of the 9,950 cases investigated in 1958-59, 6,227 cases or 62.6% of all cases involved deaths from natural causes. These deaths frequently require more extensive medical investigation and laboratory study than deaths from trauma, since a history of illness or hospitalization may not be available to the medical examiner. The popular notion that a preponderance of cases investigated by medico-legal agencies involve homicide or other acts of violence is disproved by the experience of this and similar offices. In 1958-59 there were 229 homicides investigated by the Coroner, or 2.3% of the total number of cases handled.

There were 861 cases of suicide (8.7%) investigated in 1958-59, an increase of 43 cases over 1957-58, and an increase of 29 over the preceeding year was observed in the number of suicides involving barbiturates.

Motor vehicle fatalities decreased from 961 in 1957-58 to 908 in 1958-59. This is the second consecutive year that motor vehicle fatalities have decreased. These fatal accidents accounted for 9.1% of all cases investigated by the Coroner. Collision of vehicles accounted for 504 deaths, 81 deaths resulted from non-collision accidents; and pedestrian fatalities were 323.

II. FUNCTIONS AND SERVICES OF THE DEPARTMENT

It is the responsibility of the Coroner under the laws of the State of California to investigate all cases of sudden and unexpected death within the County. This responsibility is not limited to homicides, suicides, and death under suspicious circumstances, which are commonly thought to be the province of the Coroner, but extends to deaths in which no physician attended the deceased in life, to accidents of all sorts which result in death, and to deaths attributable to industrial or occupational causes. The Coroner's investigation of these deaths is a medical investigation and supplements the investigations made by other law enforcement agencies. Investigation by the Coroner may include a visit to the scene of death by the medical examiner assigned to the case, the study of the medical history of the deceased, examination of the body, autopsy, toxicological examination of body fluids and organs, and microscopic study of tissues to reveal pathological conditions not observable on simple visual examination. Each case is a particular problem, unique in itself, and each requires a different combination of medical techniques.

The investigation conducted by the Coroner of the circumstances and cause of death permits the Coroner's Department to issue death certificates in which these circumstances and cause of death become a matter of permanent public record. The cause of death and the manner in which it occurred, as certified by the Coroner, may become the basis of criminal or civil action in the courts. In such cases the medical examiners, toxicologists, and technicians of the Coroner's Department appear as expert witnesses. It is important to observe that the Coroner's investigation is impartial, factual, and based upon scientific knowledge and experience. Members of the staff of the Department appear in court to state the facts as these have been determined, not to support the contentions of either prosecution or defense.

The investigation of the Coroner produces permanent medicolegal records of autopsies performed and laboratory investigations completed. These are available to the District Attorney, the Public Defender, law enforcement agencies of municipalities, the insurers of the deceased, and other interested public and private agencies. The primary medical records are also made available to hospitals in which the deceased were patients, or to physicians who treated them in life. For both mandatory legal reasons and equally cogent reasons of medical knowledge it is important that these records be complete, accurate, and available to those whose interest requires the study of these documents.

In addition to the primary responsibility of the Coroner for the medical investigation of cause of death, it is also the responsibility of the Department to assume custody of the bodies and property of deceased persons, the circumstances of whose deaths require the Coroner's investigation. In the central metropolitan area of the County the bodies of deceased persons are brought to the Coroner's morgue in the Hall of Justice by the personnel and equipment of the Coroner' Department. In areas lying outside of this area, this service is performed for the Coroner by cooperating mortuaries, which act for the Coroner in their districts. In districts having more than one mortuary this service is handled by rotation on a monthly basis. Under present conditions approximately one-half of all Coroner's cases are handled in the central morgue, with the remaining half being handled in districts outside the central area. All homicide and abortion cases are handled in the central morgue.

The service rendered by the Coroner in the investigation of those deaths which require his legal intervention is an essential service of local government. It is essential not only in the obvious cases of possible homicide or suicide, but in the less obvious cases of death occurring from occupational disease, industrial accident, epidemic disease, and in differentiating natural deaths from those which result from accident. The facts revealed by the Coroner's investigation can contribute to the public health as well as the public safety, may direct attention to hazardous conditions of employment, may detect the presence of unsuspected disease of epidemic nature, or reveal the existence of hazards to health which preventive measures can eliminate.

In addition to the primary function of medical investigation to determine the cause and circumstances of death, the Coroner may, in his discretion, hold a formal inquest. Transcripts of the inquest proceedings are made available to the District Attorney for review and possible action by his office. The function of the inquest is primarily that of determining criminal responsibility for death.

In the performance of its legal duties the Coroner's Department provides such services as the fingerprinting and identification of deceased persons, the notification of next of kin, notification of law enforcement agencies, the Veterans Administration, and other branches of government of the death of persons in whom these agencies have an interest.

III ORGANIZATION OF THE DEPARTMENT

The Department is headed by the Coroner, Doctor Theodore J. Curphey, and its functions are performed by six major divisions: (1) Medical (Professional); (2) Medical (Stenographic and Control); (3) Toxicology; (4) Embalming; (5) Records, and (6) Inquest.

The Medical Division is responsible for the Professional medical investigation of each Coroner's case, and for the determination of the cause and mode of death. This work is performed by Deputy Medical Examiners under the direction of the Assistant Chief Deputy Medical Examiner. In addition, the histopathology laboratory which prepares microscopic slides for the Deputy Medical Examiners is under the supervision of the Assistant Chief Deputy Medical Examiner.

The Medical Division - Stenographic and Control, is responsible for the transcribing of dictated cases, taking medical dictation, obtaining medical histories and police reports over the telephone, locating by telephone all doctors on outside runs at the various mortuaries throughout the county; answering all telephone calls for the doctors or for medical information. The Control Section is responsible for keeping account of approximately 10,000 cases per year and approximately 50,000 miscellaneous laboratory, police, case, history, and Toxicology reports, and preparing monthly statistical control reports.

The Toxicology Division is responsible for the chemical analysis of specimens submitted by the Deputy Medical Examiners for laboratory study. These specimens include blood, tissue, and other organic substances. Laboratory studies are made to determine the presence or absence of toxic agents such as the alcohols, narcotics, barbiturates, carbon monoxide, heavy metals, and other poisons. In many cases, such studies are fundamental for the positive determination of the cause of death.

The Embalming Division is responsible for the transportation of bodies of deceased persons whose deaths occur in the metropolitan area as well as for the transportation of all suspected homicide cases that occur in any part of the county. Personnel of the division have an important duty in gathering information and evidence at the scene of death, making preliminary classification as to type of death, as well as assuming custody of property found on the person of the deceased. This division

operates the Coroner's Morgue in the Hall of Justice, has custody of remains, performs restorative work and releases remains to funeral directors. In addition, personnel of this division assist Deputy Medical Examiners at the autopsy table, and take photographs of remains and organs as required.

The Records Division has responsibility for the receiving of reports of death, of maintaining the case records pertaining to all Coroner's cases; of notifying the next of kin of the deceased; of releasing remains on authorization of persons entitled to claim remains; of holding and releasing property; of issuing death certificates; and maintaining the Coroner's Register as required by law. In addition, this division receives the bulk of all incoming telephone calls requesting information regarding Coroner's cases. All personal contacts with the public, relatives of deceased are handled by this division including accompanying identification witness to view the remains of deceased, relatives, friends, etc.

The Inquest Division is responsible for the holding of formal inquests into the death of persons from unnatural causes. Purpose of the inquest is to determine if death is the result of a criminal act on the part of another. Inquests are held in the Hall of Justice, or in the area where the death occurred. Proceedings are conducted by one of two Inquest Deputies, and the verdicts are rendered by Coroner's juries convened for that purpose. The proceedings are recorded and transcripts are made available to the District Attorney, City Attorneys, and others.

SELECTED STATISTICS

TABLE No. 1

Cases investigated by the Coroner:	1957-1958	1958-59
In the Coroner's Metropolitan Area	4153	4270
In other areas of Los Angeles County	5806	5680
	9959	9950

TABLE No. 2 - MANNER OF DEATH

Natural Causes	6354	6227
Motor Vehicle Fatalities	961	908
Home Accidents	841	965
Occupational Accidents	118	99
Aircraft Accidents	77	20
Railway Accidents	22	13
Other Accidents	449	508
Suicides	818	861
Homicides	233	229
Stillbirths	50	60
Abortions	8	11
Undetermined	28	49
	9959	9950

SELECTED STATISTICS

TABLE No. 2a

DEATHS FROM NATURAL CAUSES - IN MAJOR GROUPS
(International List)

Infective and parasitic diseases	59
Neoplasms	205
Allergic, endocrine, metabolic and nutritional diseases	60
Diseases of the blood and blood forming organs	13
Mental, psychoneurotic and personality disorders	146
Diseases of the nervous system and sense organs	188
Diseases of the circulatory system	4515
Diseases of the respiratory system	630
Diseases of the digestive system	283
Diseases of the genito-urinary system	26
Diseases of pregnancy, childbirth and the puerperium	12
Diseases of the skin and cellular tissue	1
Diseases of the bones and other organs of movement	4
Congenital malformations	32
Diseases of early infancy	53
Symptoms, senility and ill-defined conditions	49
	6276

TABLE No. 2b - TOTAL DEATHS BY AGE GROUP

AGE	NUMBER OF DEATHS
Stillborn	60
Under 1 month	67
Under 1 year	436
Under 15 years	340
Under 30	622
40	649
50	1220
60	1647
70	1880
Over 70	3029
Total	9950

TABLE No. 3 - MOTOR VEHICLE FATALITIES

	1957-1958	1958-59
Pedestrians	326	323
Vehicular Collisions	525	504
Non-collision Accidents	110	81
	961	908

TABLE No. 3a - MOTOR VEHICLE FATALITIES
Incidence of Alcohol (see next page)

TABLE No. 4 - HOME ACCIDENTS

	1957-1958	1958-59
Burns and Explosions	71	102
Electrocutions	9	See Misc.
Falls	538	617
Firearms	11	16[5]
Mechanical Asphyxia	77*	26
Drowning		47[1]
Miscellaneous	24	59
C.O.		37[3-4]
Poisoning	106**	61[2]
Violence of Undetermined Origin	5	See Misc.
	841	965

* 11 Drownings in home swimming pools by children included in this figure.
** 10 Carbon monoxide deaths from gas heaters burning in closed room in this figure.
1 includes 21 children in private pools
2 includes 30 accident or suicide undetermined
3 includes 2 accident or suicide undetermined
4 includes 10 gas heaters in closed rooms
5 includes 2 accident or suicide undetermined

TABLE No. 3a - INCIDENCE OF - ALCOHOL - AUTO ACCIDENTS

	Total	No Test	Negative	.01%-.04%	.05%-.09%	.10%-.15%	Above 15%	Total Cases .15% or Above
Drivers	411	112	158	8	17	32	84	20.4%
Pedestrians	323	134	124	2	4	11	48	14.8%
Passengers	174	49	81	9	12	6	17	9.7%

SELECTED STATISTICS

TABLE No. 5 - OCCUPATIONAL ACCIDENTS

	1957-1958	1958-59
Axphyxia	0	5
Burns	14	12
Crushing	19	12
Electrocution	6	9
Explosions	3	
Falls	28	31
Infection	21	
Machinery	0	4
Miscellaneous	27	
Others	0	22
Poisoning	0	4
	118	99

SELECTED STATISTICS

TABLE No. 6 - OTHER ACCIDENTS

	1957-1958	1958-59
Burns and Explosions	9	16
Drowning	0	43[1-2]
Falls	284	342
C.O.	0	3[4]
Firearms	10	4
Mechanical Asphyxia	67*	See C.O. and Drowning
Miscellaneous	45	72[5]
Poisoning	27**	28[3]
Violence of Undetermined Origin	7	See Misc.
	449	508

* 3 Drownings of children in public pools included in this figure.
** Above total includes 3 carbon monoxide deaths resulting from gas heaters in closed rooms.
1 includes 6 children-public pools
2 includes 2 accident or suicide undetermined
3 includes 9 accident or suicide undetermined
4 includes 1 accident or suicide undetermined
5 includes 8 mode undetermined

SELECTED STATISTICS

TABLE No. 7 - SUICIDES

	1957-1958	1958-59
Shooting	276	301
Poisoning (Barbiturates	196	225
(Others	54	77
Jumping	29	41
Drowning	0	
Hanging	112	103
Carbon Monoxide - Auto Exhaust	89	70
All Others	62	38
	818	861

TABLE No. 8 - HOMICIDES

	1957-1958	1958-59
Assault	11	19
Poisoning	1	0
Shooting	135	138
Stabbing	41	39
Strangulation	14	9
Suffocation	2	0
All Others	29	24
	233	229

TABLE No. 9 - HOMICIDES - SUICIDES
Incidence of Alcohol (see next page)

TABLE No. 10 - MISCELLANEOUS DATA

	1957-1958	1958-59
Number of autopsies performed	4632	4661
Bodies embalmed for which fees were collected	3124	2683
Bodies embalmed for which no fees were collected	461	851
Bodies processed at Coroner's Mortuary Hall of Justice	4153	4270
Miles traveled by Medical Examiners to conduct investigations and appear as witnesses	77338	108377
Non-Coroner's cases (cases reported to Coroner but found not to be Coroner's cases)	510	304
Number of inquests held	425	420
Number of miles traveled by Coroner's vehicles to transport bodies	33777	39840

TABLE No. 9 - INCIDENCE OF ALCOHOL HOMICIDES - SUICIDES

	Total	No Test	Neg.	.01%-.04%	.05%-.09%	.10-.15%	Above 15%	Percent of cases 15% or above
Homicide	229	53	84	9	7	14	62	27.0%
Suicide	861	221	423	31	42	42	102	11.8%

SELECTED STATISTICS

TABLE No. 11 - LABORATORY TESTS

	1957-1958	1958-59
Microscopic examinations	14830	19,275
Bacteriological examinations	34	26
Cytology examinations	230	143
Gross specimens prepared	12	4
Neuropathology brain studies	235	191
Special tissue stains	69	40

TABLE No. 12 - PHOTOGRAPHY

Number of negatives made and processed	1112	1045
Number of prints made and processed	2212	2100
Number of color slides prepared	158	58
Number of black and white slides prepared	120	0
X Ray		5
Enlargements		52

V. EXPENDITURES

	1957-1958	1958-59
SALARIES AND WAGES	$486,525.30	541,226.98
MAINTENANCE AND OPERATION	50,677.09	53,126.97
CAPITAL OUTLAY	23,746.60	2,007.11
	$560,948.99	596,361.06

VI. REVENUES COLLECTED

SALARY FUND:		
EMBALMING FEES	$ 80,237.53	77,190.57
SALE OF TRANSCRIPTS	6,441.52	6,923.91
	$ 86,679.05	84,114.48
GENERAL FUND:		
WITNESS FEES	488.50	409.09
REFUND OF TRANSPORTATION	916.20	533.03
	$ 1,404.70	942.12